So you want to be ... a chest physician

Introduction

Respiratory problems cause 30–40% of acute medical admissions, and are important co-morbidities in many more. The respiratory physician needs a wide base of experience in general internal medicine, and also a full grasp of the speciality.

Respiratory physicians were involved in early trials of antituberculous therapy and pioneered the use of 'evidence-based medicine'. Working groups produced guidelines on tuberculosis, asthma and chronic obstructive pulmonary disease in the 1990s which standardized and improved care. Multidisciplinary working now forms the key to rapid and effective investigation of patients with lung cancer, but is also effective for other patients with interstitial lung disease, sleep apnoea or difficult asthma.

Recently there has been an increased emphasis on subspecialization, where not all respiratory physicians have all skills, but the team as a whole covers all areas of expertise. New techniques of investigation, with interventional and therapeutic bronchoscopy, medical thoracoscopy and physician ultrasound examination of the chest give us better tools for diagnosis and treatment. The new challenges from multidrug resistant and extremely drug resistant tuberculosis and human immunodeficiency virus (HIV)-associated lung disease remind us that the pattern of respiratory infection is always changing.

There is a real need for keen and committed doctors with an interest in patients with respiratory disease to join the speciality.

Training

After a broad training in the foundation years, followed by core medical training at ST1–2 level, potential trainees apply for further training in general and respiratory medicine at ST3 level. By this stage they should have had some respiratory training, and become skilled in some procedures such as chest aspiration and drain insertion.

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They need to show that they are committed to the speciality and have a wide basic understanding of respiratory diseases.

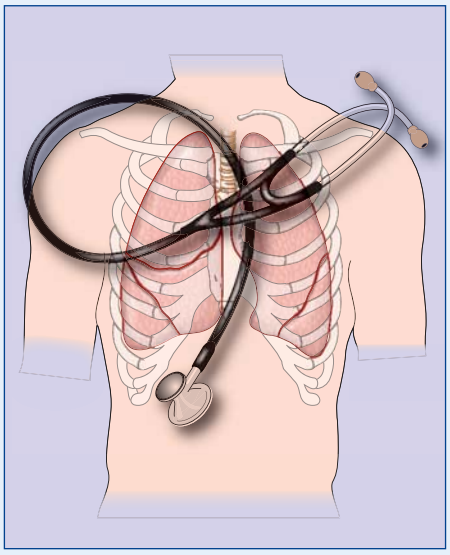
The first year or two of the specialist training years are spent in district general hospitals working as a specialist registrar, and gaining experience in the clinic management of patients with respiratory disease, skills in bronchoscopy and tuberculosis treatment, and work as part of the multidisciplinary lung cancer team. There will be a commitment to acute and on call emergency medicine during this time.

Later years will include intensive care training, more specialist respiratory placements including training in sleep medicine, tuberculosis management, pulmonary physiology, and more training including interventional bronchoscopy and thoracoscopy. Many trainees take 2–3 years out of programme at this stage to carry out an MD or PhD research project, or to spend 2 years in intensive care training.

Modern training includes skills training and assessment in the workplace with competency assessment for practical skills. A knowledge-based exit examination is planned for all trainees. By the time the trainee has completed training and obtained specialist certification he/she should have developed skills in multidisciplinary working, good communication skills, an empathetic approach to patients with chronic disorders, and have a wide experience of general and emergency medicine. Some management training and training in teaching will prepare trainees for a life as a consultant.

What will the future be like?

Some respiratory physicians will work in specialized areas, such as cystic fibrosis or intensive care, or in the acute assessment unit but most will carry a large emergency medical load of work, combined with caring for patients with asthma, chronic obstructive pulmonary disease, lung cancer and interstitial lung disease. Some of this work will be done in the community, and some hospital based. Tuberculosis treatment will continue to be lead by chest physicians.



There will be constant new developments of technology and new practical procedures including the use of stents, laser therapy and treatment for bullous disease. Thoracoscopy to investigate patients with pleural effusions will become standard.

Respiratory consultants will work with scientists to translate scientific research into practical treatments. Constant review of practice through audit, research and development of best practice guidelines will improve care delivery. New challenges will arise, such as multi-drug resistant tuberculosis or new infections such as severe acute respiratory syndrome. This all makes respiratory medicine an exciting and developing speciality. The websites listed below give a view of the speciality and training. BJHM

Conflict of interest: none.

Further information

www.brit-thoracic.org.uk
www.rcplondon.ac.uk
www.thoracic.org
http://dev.ersnet.org/

KEY POINTS

- Respiratory medicine is a developing speciality with many new techniques for investigation and treatment, and constant new challenges.
- A wide general medical base is essential.
- There is a wide diversity of sub-specialization on top of a general workload.
- Multidisciplinary working with radiologists, pathologists and specialist nurses is the key to providing efficient high quality care.
- For more information talk to members of your local respiratory team, both senior and junior and contact www.brit-thoracic.org.uk.